IDAHO DEPARTMENT OF
HEALTH & WELFARE

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January 15, 2010

David Rowe, Administrator
Madison Memorial Hospital
PO Box 310
Rexburg, Idaho 83440-0310

RE: Madison Memorial Hospital, Provider #130025

Dear Mr. Rowe:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at your facility, Madison Memorial Hospital, on January 6, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **January 28, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

Eric Mundell

ERIC MUNDELL, REHS
Health Facility Surveyor
Facility Fire Safety and Construction Program

EM/lj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130025	A. BUILDING 02 B. WING _____	01/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON MEMORIAL HOSPITAL	450 EAST MAIN STREET REXBURG, ID 83440

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is multifaceted remodels/additions with last addition for use released June 27, 2008. The three level structure is a Type II (222) building that is fully sprinkled with interconnected fire alarm system throughout. The facility is currently licensed for 49 patients. The following deficiencies were cited during the fire/life safety survey conducted on January 6, 2010. The facility was surveyed under the Life Safety Code 2000 Edition New Health Care Occupancy and 42 CFR 482.41. The surveyor conducting the Life Safety survey was: Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety & Construction Program	K 000	RECEIVED FEB 04 2010 FACILITY STANDARDS	
K 027	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	K 027	K 027 Oakland Construction was made aware of the need to fix the astragals on smoke barrier cross-corridor doors in the Med/Surg department, fire door adjacent to room 2035, OB overflow doors, x-ray staff only door, and OR/surgery door on 1/26/10 and have committed to fix it by 2/26/10. After this date "Clyde", Director of Engineering, and "Wade", Construction supervisor, will do a walk through to verify these doors have been corrected. Walk through –	2/26/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

PERFORMANCE IMPROVEMENT DIRECTOR 2/3/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 027	Continued From page 1 This Standard is not met as evidenced by: Based on observation, it was determined that the facility had not ensured installation of astragals on cross-corridor smoke doors on two of three levels sampled (e.g., medical/surgical, and imaging departments). The census was 23 on the day of the survey. The findings include: Observation on January 5, 2010 during tour between 11:30 a.m. and 2:25 p.m. disclosed that astragals had not been installed on smoke barrier cross-corridor doors in the medical/surgical department, on fire doors adjacent to room 2035, on the new doors installed in the corridor leading to the "OB overflow", on the X-ray medical imaging door "staff only door", O.R. surgery hallway door. All gaps observed to be exceptionally wide and without astragals were to the point the width would de-classify the doors as "smoke resisting". The conditions were observed by both surveyor and Maintenance Director #1. 8.3.4 Doors. 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. A.8.3.4.1 The clearance for proper operation of smoke	K 027		

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K 027	Continued From page 2 doors is defined as 1/8 in. (0.3 cm). For additional information on the installation of smoke-control door assemblies, see NFPA 105, Recommended Practice for the Installation of Smoke-Control Door Assemblies. 18.3.7.8 Rabbets, bevels, or astragals shall be required at the meeting edges, and stops shall be required at the head and sides of door frames in smoke barriers. Positive latching hardware shall not be required. Center mullions shall be prohibited.	K 027		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This Standard is not met as evidenced by: Based on observation, it was determined that the facility had not ensured that for two of seven hazardous areas sampled, the self-closing doors of the two rooms were not maintained as required. The census was 23 on the day of the survey. The findings include: Observation on January 5, 2010 at 1:40 p.m. disclosed that doors had been propped open or disassembled. The door of Mechanical Room #1 had been propped open by carpet installers. The room contained six gas-fired boilers and fuel-fired heaters; the door was observed to be propped open by the installers during observations for two	K 029	K 029 Oakland was informed that doors have been propped open and door closers have been disabled by construction workers. They have informed their sub contractors at their weekly sub meeting on 01/26/10 and fix the problems. "Clyde" and "Wade" walked through the space on 01/28/10 and found all closers operating properly with no props on the doors. The Engineering staff have been alerted to this issue and have been asked to report if they find doors propped open the "Clyde". monitored 1/26/10 tw	

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K 029	Continued From page 3 subsequent days. In addition, the self-closure arm installed on the door of the "Purchasing" central supply department that is used to swing the door shut and latch had been disconnected by construction workers. Within the central supply rooms were typical fuel loads for a hazardous area and by calculation, approximately 13.6 gallons of alcohol based handrub bottled solutions. Lack of closed doors potentially allows hot gases and smoke to penetrate throughout the smoke compartment in the event of a fire emergency. The observations were observed mutually by Maintenance Director #1 and surveyor. Actual NFPA 101 reference: 18.3.2.1* Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated. 3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.	K 029		
K 039	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited	K 039		

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K 039	Continued From page 4 care facilities and psychiatric hospitals, width of aisles or corridors is at least 6 feet. 18.2.3.3, 18.2.3.4 This Standard is not met as evidenced by: Based on observation, it was determined that the facility had not ensured a complete and clear path through corridors serving as exit access for three of eight corridors and one of two stairwells sampled. The census was 23 on the day of the survey. The findings include: Observation during tour of the building from January 5, 2010 at 11:12 a.m. and January 6, 2010 at 9:44 a.m. disclosed the following obstructions in corridors and one stairwell: 1) the back exit corridor leading from the "Paragon" dining room to the back exit was blocked by a table and four chairs; 2) the corridor leading from the O.R. suite to the exit access corridor was blocked at the doorway area by a shredder, refuse container, and 55 gallon Western Recycling Bin and was being used as a gown up area with bookshelves hung in the corridor access (projections under 6 ft 8 inches in corridor); 3) the "breakdown corridor" which is the back exit access for the Central Supply/Clean Sterile area was reduced to a corridor width varying from 31 inches to 38 inches. Corridor width was not maintained at a minimum of 44 inches. In addition, the stairwell landing within the Stairwell B was observed to have a wooden door used during construction that was stored on the landing. The restricted area at the top landing would potentially interfere with use of the "Stair Chair" or any other number of residents or staff	K 039	K 039 The table and chairs in the Paragon were moved on 1/28/10 out of path of exit. "Don", Food Service Manager, will monitor to ensure it stays clear. If the exit does not stay clear of the table and chairs they will be permanently removed from area by the Engineering Department. "Betty", Director of Surgery Services and Engineering have worked to get different shelving installed next to the desk in the corridor leading form the O.R. suits to the exit to prevent this corridor being blocked. The shelving is scheduled to be here and installed by 02/12/10. The shred box has been moved into decontam room. The surgery staff have been notified and will monitor to keep the exits clear. In order to provide a 44 inch exit in the break down corridor "Betty" has talked with the Striker representative and he will have his box out by 02/19/10. "Betty" will get some asset disposal forms filled out by 02/12/10 so that we can move other pieces of unused equipment out of the way and keep things on the carts. "Jearold" has been assigned to monitor this hall so it does not move into the 44 inch range. Oakland removed the door in stairwell B on 01/27/10. As Engineering and Housekeeping clean and use the stairs they will monitor to make sure nothing else wanders into this space. Monitor corridor & stairwells -	1/28/10 a. 2/12/10 b. 2/19/10 c 2/12/10 1/27/10 d

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K 039	Continued From page 5 using the stairwell in an emergency. The observations were jointly observed by the surveyor and Maintenance Director #1. Actual NFPA 101 reference: 7.1.5* Headroom. Means of egress shall be designed and maintained to provide headroom as provided in other sections of this Code and shall be not less than 7 ft 6 in. (2.3 m) with projections from the ceiling not less than 6 ft 8 in. (2 m) nominal height above the finished floor. The minimum ceiling height shall be maintained for not less than two-thirds of the ceiling area of any room or space, provided the ceiling height of remaining ceiling area is not less than 6 ft 8 in. (2 m). Headroom on stairs shall be not less than 6 ft 8 in. (2 m) and shall be measured vertically above a plane parallel to and tangent with the most forward projection of the stair tread. 18.2.3.3* Aisles, corridors, and ramps required for exit access in a hospital or nursing home shall be not less than 8 ft (2.4 m) in clear and unobstructed width. Where ramps are used as exits, see 18.2.2.6. Exception No. 1*: Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (112 cm) in clear and unobstructed width.	K 039		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1	K 046	K 046 "Greg", Biomedical Electronics Technician, will have a form created by 2/12/10 to document to show that we are checking the battery operated light monthly for 30 seconds and annually for 1.5 hours. "Stacy", Engineering Secretary, has created a PM to make sure that this is checked monthly. "Clyde" will review on a monthly basis the PM schedule to ensure that this is being completed as scheduled.	2/12/10 zm

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K 046	Continued From page 6 This Standard is not met as evidenced by: Based on record review and staff interview, it was determined that the facility had not ensured that monthly testing was occurring in new operating rooms placed in service equipped with emergency lighting. The findings include: Record review on January 5, 2009 at 10:09 a.m. disclosed that there was no record of monthly testing of battery packs in emergency lighting located in the operating rooms. Staff interview on January 5, 2009 at 10:10 a.m. disclosed that new battery operated emergency lights had been placed in the operating rooms for additional emergency lighting. Staff stated that monthly logs were not available for review to show that monthly testing was being conducted to determine fully operational lighting. Actual NFPA 101 reference: 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1-1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046		
K 050	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050	K 050 "Stacy" has added quarterly fire drills to "Jack's", Biomedical Technician, PM work list. As this assignment will populate on "Jack's" work list on a quarterly basis "Jack" will ensure that the fire drills are conducted on various shifts and record in the fire drill log when it was done and any issues that were identified. The areas for improvement will be shared with "Luann", Safety Officer, who will make assignments to have them corrected. The data from the fire drills will be reviewed in Safety Committee on a quarterly basis. Our next fire drill has been scheduled to be done by 2/28/10.	2/20/10 ew

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K 050	Continued From page 7 varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This Standard is not met as evidenced by: Based on record review and staff interview, it was determined that the facility had not ensured fire drills were conducted for four of four quarters sampled. The census was 23. The findings include: Record review on January 5, 2010 at 10:14 a.m. disclosed that there was no record of a planned or organized fire drill for 2009. There was no evidence of one drill per shift per quarter as required. Maintenance Director #1 stated on January 5, 2010 at the time of record review that the drills were not held but a series of false alarms were used as documentation and as substitute for fire drills. The last documented fire drills were the last quarter of 2008. Staff further stated that most personnel of the hospital did not really respond or participate in the false alarms due to "complacency" and that most ignored the situation. There was no fire drill record to indicate who participated, what problems might be identified during drills or who organized drills in a strategic planning manner. Actual NFPA Life Safety Code 101 reference:	K 050		

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K 050	Continued From page 8 18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. A.18.7.1.2 Many health care occupancies conduct fire drills without disturbing patients by choosing the location of the simulated emergency in advance and by closing the doors to patients ' rooms or wards in the vicinity prior to initiation of the drill. The purpose of a fire drill is to test and evaluate the efficiency, knowledge, and response of institutional personnel in implementing the facility fire emergency plan. Its purpose is not to disturb or excite patients. Fire drills should be scheduled on a random basis to ensure that personnel in health care facilities are drilled not less than once in each 3-month period. Drills should consider the ability to move patients to an adjacent smoke compartment. Relocation can be practiced using simulated patients or empty wheelchairs.	K 050	K 051 Simplex has been contacted and a representative will be here on 02/02/10 to assess what it will take to do an annual check on the system. They will then give us a price and we will issue a purchase order so it can be done. "Stacy" has made a PM to make sure it is done annually. "Jack" has been assigned to make sure that Simplex is contacted and the fire alarm system has been tested annually. "Clyde" will review the PM schedule on a monthly basis to ensure this is being done as scheduled.	2/2/10
K 051	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components,	K 051		

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K 051	Continued From page 9 devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 This Standard is not met as evidenced by: Based on record review and staff interview, it was determined that the facility had not ensured that fire alarm systems were tested/maintained as required for twelve of twelve months sampled. The census on the day of the survey was 23. The findings include: Record review on January 5, 2010 at 9:45 a.m. disclosed that the "computer controlled graphics" of the computer system did not have the capability to generate reports of monthly fire alarm testing, nor was a report from the fire alarm contractor, who would conduct an annual fire alarm inspection, available for review. Maintenance Director #1 stated during interview at the same time as the record review that monthly tests were not being conducted and that due to facility-wide construction, annual fire alarm inspections had not been completed except prior to construction begining.	K 051		

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K 051	Continued From page 10 Because the reports weren't available and the tests not administered, the system was not maintained monthly and annually in accordance with NFPA 72. Actual NFPA 101 reference: 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction.	K 051		
K 054	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This Standard is not met as evidenced by: Based on record review and staff interview, it was determined that the facility had not ensured that all smoke detectors had received necessary maintenance to assure adequate sensitivity. The census was 23 on the day of the survey. The findings include: Record review on January 5, 2010 at 9:45 a.m. disclosed that the facility records did not show that sensitivity testing of smoke detectors had	K 054	K 054 Before the smoke detectors can be tested the new GCC needs to be installed. It was discussed during construction meeting on 01/28/10 with Oakland what needs to be done. Oakland reported that they will have this done by 3/10/10. Once Oakland has completed "Stacy" will schedule a PM to establish a baseline and a schedule to have the smoke detectors maintained, inspected and tested on an annual basis. "Clyde" will review the PM schedule on a monthly basis to ensure this is being done as scheduled. 3/10/10 ew	

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K 054	Continued From page 11 been conducted throughout the building for new installations. The facility was unable to provide documentation of any current or complete sensitivity testing of smoke detectors. There was no written record of test cycles by the fire alarm contractor; no documentation or reports of status of the system detectors was available for review when, during staff interview, Maintenance Director #1 was asked about test results on the system and questioned about the status of the reports. Also, a list of "false alarms" and alarm activations was presented during the record review which disclosed many false alarm episodes during the first half of 2009 caused by construction, paint or dust. The increase of false alarms may indicate that the smoke detectors would decrease in sensitivity over time. The maintenance director stated that the information available to him to check on condition of the fire alarm control panel was real time only and that only current condition was able to be displayed. The conditions displayed did not and could not include a report on sensitivity testing for each smoke detector according to the director. The finding was acknowledged and verified by the Maintenance Director. Actual NFPA standard: NFPA 72, section 7-3.2.1 Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of	K 054		

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K 054	Continued From page 12 detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.	K 054		
K 056	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This Standard is not met as evidenced by: Based on observation, it was determined that the facility had not ensured the automatic fire sprinkler system had been maintained as required after a major remodeling and additions to the structure. The census was 23 on the day of the survey. The findings include: Observation on January 5, 2010 at 11:37 a.m. disclosed that mixed heads were installed in the corridor leading from the medical/surgical unit to the Paragon cafeteria just outside of and adjacent	K 056	K 056 By 02/09/10, Shilo Sprinkler Company will put new tags on the fire risers. "Stacy" has assigned a PM to "Jack" to show that maintenance of the automatic fire sprinkler system has been done. "Clyde" will review the PM schedule on a monthly basis to ensure this is being done as scheduled. "Clyde" did a visual check on 01/29/10 which reviled that all the sprinkler heads have been changed by Oakland Construction. 1/29/10 dw	

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K 056	Continued From page 13 to the physical therapy unit (specifically the corridor area from "Performance Improvement to the custodial corridor door). The mixed head condition was confirmed by Maintenance Director #1. The mixed heads are of varying performance and thermal sensitivity thus providing opportunity for activation of quick response heads only, in case of fire emergency. The ordinary heads may not adequately respond being adjacent to and in the same compartment as quick response sprinkler heads. Actual NFPA 13 reference: 5-3.1.5.2 When existing light hazard systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed.	K 056		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on record review, observation and staff interview, it was determined that the facility had not ensured maintenance was accomplished as required. The census was 23. The findings include: Record review on January 5, 2010 at 10:20 a.m.	K 062	K 062 Shilo Sprinkler Company has been contacted and will be here on 02/09/10 to do the annual inspection of the fire risers and tamper switches. "Stacy" will create a PM and assign it to "Jack" so we do not forget to do it next year. "Clyde" will review the PM schedule on a monthly basis to ensure this is being done as scheduled.	2/9/10 cw

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K 062	Continued From page 14 disclosed that no annual automatic fire extinguishing system check had been performed as required. Maintenance Director #1 disclosed at the time of the record review that the contracting agency for automatic fire sprinkler systems had not provided a report of an annual inspection. Failure to have the annual inspection testing, although the system had been expanded, would potentially cause equipment failure during activation. Observations on January 5, 2010 at 2:45 p.m. and January 6, 2010 at 9:03 a.m. disclosed that separate inspection tags, affixed on the two automatic fire sprinkler risers in mechanical room #2 and #5 showed that the last annual inspection dates were December 2005 and May 2008 respectively. Maintenance Director #1 stated at the time of the record review that the systems had not been inspected and were not done due to construction on the building. Actual NFPA 101 references: 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.	K 062		

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K 062	Continued From page 15 1-9 Inspection. 1-9.1 System components shall be inspected at intervals specified in the appropriate chapters. 1-9 Inspection. 1-9.1 System components shall be inspected at intervals specified in the appropriate chapters. 1-9.2* Inspection and periodic testing determine what, if any, maintenance actions are required to maintain the operability of a water-based fire protection system. The standard establishes minimum inspection/testing frequencies, responsibilities, test routines, and reporting procedures but does not define precise limits of anomalies where maintenance actions are required. 1-10 Testing. 1-10.1 All components and systems shall be tested to verify that they function as intended. The frequency of tests shall be in accordance with this standard. Following tests of components or portions of water-based fire protection systems that require valves in order to be opened or closed, the system shall be returned to service upon verification that all valves are restored to their normal operating position. Plugs or caps for auxiliary drains or test valves shall be replaced. See Standard NFPA 25, Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Sprinklers Inspection Annually 2-2.1.1. etc. 1-8* Records. Records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon	K 062		

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K 062	Continued From page 16 request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and preaction valves. A-1-8 Computer programs that file inspection and test results should provide a means of comparing current and past results and should indicate the need for corrective maintenance or further testing. Acceptance test records should be retained for the life of the system or its special components. Subsequent test records should be retained for a period of 1 year after the next test. The comparison determines deterioration of system performance or condition and the need for further testing or maintenance.	K 062		
K 066	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.	K 066	K 066 Since the ground is too frozen to install posts at this time, temporary no smoking signs will be posted by 02/15/10 at the access and egress points of the helicopter pad and permanent signs will be completed by 04/01/10 when the ground is thawed. "Clyde" will verify the temporary signs are placed by 02/15/10, along with verifying that the permanent signs have been installed by 04/01/10.	2/15/10

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K 066	Continued From page 17 (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 18.7.4 This Standard is not met as evidenced by: Based on observation, it was determined that the facility had not ensured the campus wide no-smoking policy would preclude individuals, waiting at the landing pad of the landing zone for helicopters, from knowing what the smoking policy was on campus (or at the helicopter pad itself). The findings include: Observation on January 5, 2010 at 1:25 p.m. disclosed that "No Smoking" signs were not posted at the perimeter of the landing pad/zone used by the facility for patient emergency evacuation/reception by helicopter. No Smoking signs were not posted at the access and egress points of the helipad. Actual NFPA 418 reference: 2.5 No Smoking. No smoking shall be permitted within 50 ft (15.2 m) of the landing pad edge. No smoking signs shall be erected at access/egress points to the heliport.	K 066		2/11/10 cw
K 106	NFPA 101 LIFE SAFETY CODE STANDARD Hospitals, and nursing homes and hospices with life support equipment, have a Type I Essential Electrical System powered by a generator with a	K 106	K 106 The parts to install battery operated lights in the generator room were ordered 02/01/10 and they will be installed by 2/11/10 by "Greg". "Stacy" has added testing these lights/ batteries to the OR battery light PM for "Greg" to do annually. "Clyde" will review the PM schedule on a monthly basis to ensure this is being done as scheduled.	

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K 106	Continued From page 18 transfer switch and separate power supply. The EES is in accordance with NFPA 99, 3.4.2.2, 3.4.2.1.4. This Standard is not met as evidenced by: Based on observation, it was determined that the facility had not ensured emergency lighting was provided in the auxiliary generator room. The findings include: Observation on January 5, 2010 at 1:25 p.m. disclosed that the auxiliary generator room was not equipped with battery powered emergency lighting to supply the room with emergency lighting in case of motor or generator failure. The condition was confirmed by Maintenance Director #1. Refer to K tags 046 and 144 regarding battery lighting testing and NFPA 110 references. Actual NFPA 110 reference: 5-3 Lighting. 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.	K 106		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K 144 In the construction meeting 01/28/10 it was discussed with Oakland that we need a hard copy of the generator data. Oakland has agreed to get this to us by 2/26/10. "Stacy" has created a PM to have a monthly report run to verify testing of the auxiliary generator. . "Clyde" will review the PM schedule on a monthly basis to ensure this is being done as scheduled.	2/26/10

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K 144	Continued From page 19 This Standard is not met as evidenced by: Based on record review and staff interview, it was determined that the facility had not ensured documentation had been completed for auxiliary generator tests conducted. The census on the day of the survey was 23. The findings include: Record review on January 5, 2010 at 9:50 a.m. disclosed that the weekly tests conducted for the auxiliary generator were not capable of being documented on the new computer system (only monthly testing was required - see below). A written record of all tests was not available for review. Staff interview with Maintenance Director #1 during record review disclosed that a record of operational testing had not been maintained and that all information was "real time" only from computer generated information (readout only upon unit current performance/status). No information was available concerning operating parameters for the auxiliary generator including mechanical/electrical specification printout or historical operational record. Actual NFPA 99 reference: 3-4.4.1 Maintenance and Testing of Essential Electrical System. 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and	K 144		

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K 144	Continued From page 20 associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing. 1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. 3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures. 3-5.1 Sources (Type 2 EES). The requirements for sources for Type 2 essential electrical systems shall conform to those listed in 3-4.1.	K 144		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K 147 The electrical cord used on the loading deck was removed on 1/27/10. The items blocking the fire panel on level 3 were removed on 01/27/10. "Luann" has added to the safety check list a prompt to look for improper use of electrical cords and for items blocking the fire panels. An e-mail was also sent from "Clyde" informing staff concerning the use of electrical cords and keeping access to fire panels clear.	1/27/10

+ Safety check list

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K 147	Continued From page 21 This Standard is not met as evidenced by: Based on observation, it was determined that wiring installed to heat an oil reservoir was not an approved installation and an electrical room was not maintained as required for two of five areas sampled. The census was 23. The findings include: Observation on January 5, 2010 at 1:57 p.m. disclosed that the oil reservoir heating device of the cardboard crusher, purchased at the local hardware store and located on the loading deck was connected to an extension cord. The extension cord is not approved permanent installation. The heating device was used to heat the oil tank of the crusher and was not installed for permanent use (there had been multiple days of subzero weather when the heater would be plugged in and used). The surveyor and Maintenance Director #1 observed the extension cord. In addition, fire alarm and electrical control panels were obstructed in the custodial closet. The closet, located on Level III as the housekeeping closet was jammed with boxes of Christmas and Halloween decorations stored up against the steel circuit panels. Access into the room to the panels was completely obstructed. Actual NFPA 70 reference: 110-3. Examination, Identification, Installation, and Use of Equipment (a) Examination. In judging equipment, considerations such as the following shall be evaluated: 1. Suitability for installation and use in conformity	K 147		

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K 147	Continued From page 22 with the provisions of this Code FPN: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Suitability of equipment may be evidenced by listing or labeling. ARTICLE 100 -- Definitions Approved. Acceptable to the authority having jurisdiction. Listed. Equipment, materials, or services included in a list published by an organization that is acceptable to the authority having jurisdiction and concerned with evaluation of products or services, that maintains periodic inspection of production of listed equipment or materials or periodic evaluation of services, and whose listing states that either the equipment, material, or services meets identified standards or has been tested and found suitable for a specified purpose. ARTICLE 110 - Requirements for Electrical Installations (b) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 30 in. (762 mm), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels.	K 147		
K 211	NFPA 101 LIFE SAFETY CODE STANDARD	K 211		

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K 211	Continued From page 23 Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This Standard is not met as evidenced by: Based on observation, it was determined that the facility had not ensured alcohol based hand rub dispensers were installed according to NFPA and CMS requirements. The census on the day of the survey was 23. The findings include: Observation on January 5, 2010 disclosed that two separate dispensers for alcohol based hand sanitizers were installed above two outlets in the Emergency Department. The dispensers were located above an ignition source. An additional dispenser was installed adjacent to an ignition source in the main lobby area adjacent to the Emergency Department and close to where the old time clock had been installed. NFPA TIA (Tentative Interim Amendment 03-06): NFPA 101-2003 Life Safety Code®	K 211	K 211 A work order was issued to "Corey", Maintenance Technician, to have the hand sanitizers in the ER and security desk moved by 2/15/10. "Clyde" will do a walkthrough of the building by 2/15/10 to verify that all hand sanitizers have been properly placed.	2/15/10 CM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130025	A. BUILDING 02 B. WING _____	01/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON MEMORIAL HOSPITAL	450 EAST MAIN STREET REXBURG, ID 83440

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K 211	Continued From page 24 TIA Log No. 769 Reference: Chapter 18 and 19 Comment Closing Date: December 10, 2003 Submitter: Dale Woodin, American Society for Healthcare Engineering 1. Add a new 18.1.1.5 and 19.1.1.5 and renumber other sections accordingly. 18.1.1.5 (19.1.1.5) Alcohol-Based Hand-Rub Solutions. It shall be recognized that certain clinical hand hygiene needs of health care staff and visitors require alcohol-based hand-rub solutions (Class 1B flammable liquid) to be installed in egress corridors, in rooms, and in suites of rooms. In such instances, the authority having jurisdiction shall make appropriate modifications to those sections of the Code to permit the installation and maximum in-use quantities of alcohol-based hand-rub products. 18.1.1.5.3 (19.1.1.5.3) The dispensers shall not be installed over or directly adjacent to an ignition source.	K 211		

Bureau of Facility Standards

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B 000	16.03.14 Initial Comments The facility is multifaceted remodels/additions with last addition for use released June 27, 2008. The three level structure is a Type II (222) building that is fully sprinkled with interconnected fire alarm system throughout. The facility is currently licensed for 49 patients. The following state deficiencies were cited during the fire/life safety survey conducted on January 6, 2010. The facility was surveyed under the Life Safety Code 2000 Edition New Health Care Occupancy and IDAPA 16.03.14 Rules and Minimum Standards for Hospitals in Idaho. The surveyor conducting the Life Safety survey was: Eric Mundell REHS Health Facility Surveyor Facility Fire/Life Safety & Construction Program	B 000	RECEIVED FEB 04 2010 FACILITY STANDARDS See attached for plan of action.	
BB499	16.03.14.510.01 Fire & Life Safety Standards, General Require 510. FIRE AND LIFE SAFETY STANDARDS. Buildings on the premises used as a hospital shall meet all the requirements of local, state, and national codes concerning fire and life safety that are applicable to hospitals. (10-14-88) 01. General Requirements. General requirements for the fire and life safety standards for a hospital are that: (10-14-88) a. The hospital shall be structurally sound and shall be maintained and equipped to assure the safety of patients, employees, and the public. (10-14-88)	BB499		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Performance Improvement Director 2/3/10

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130025	A. BUILDING 02 B. WING _____	01/06/2010

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BB499	Continued From Page 1 b. On the premises of all hospitals where natural or man-made hazards are present, suitable fences, guards, and railings shall be provided to protect patients, employees, and the public. (10-14-88) This Rule is not met as evidenced by: Refer to federal CMS form 2567 and K Tags K027, K029, K039, K046, K050, K051, K054, K056, K062, K066, K106, K144, K147, K211.	BB499		
BB504	16.03.14.510.06 Report of Fire 06. Report of Fire. A separate report on each fire incident occurring within the hospital shall be submitted to the Department within thirty (30) days of the occurrence. The reporting form, "Facility Fire Incident Report," shall be issued by the Department to secure specific data concerning date, origin, extent of damage, method of extinguishment, and injuries, if any. (10-14-88) This Rule is not met as evidenced by: Based on record review and staff interview it was determined that the facility had not ensured that the facility had reported a fire within 30-days after occurrence. The findings include: Record review on January 5, 2010 at 10:00 a.m. disclosed that the a fire was documented on a "false alarm" list of false alarm incidents, when the occurrence was actually real on February 21, 2009. Interview of Maintenance Director #1 on January 5, 2010 at 10:15 a.m. disclosed that there had been a fire occur in the old kitchen deep fat fryer and that it had been allowed to "burn out". Review of an incident report provided by Biomedical Technician #1 disclosed that the fryer in question was immediately taken out of	BB504		

Bureau of Facility Standards

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BB504	Continued From Page 2 service and replaced with a new unit on February 23, 2009. The fire had not been reported to Facility Standards by facility administration within 30 days as required by state rule.	BB504		

Madison Memorial Hospital's Report of Plan of Correction to the Bureau of Facility Standards Life Safety Survey

BB 499

K 027

Oakland Construction was made aware of the need to fix the astragals on smoke barrier cross-corridor doors in the Med/Surg department, fire door adjacent to room 2035, OB overflow doors, x-ray staff only door, and OR/surgery door on 1/26/10 and have committed to fix it by 2/26/10. After this date "Clyde", Director of Engineering, and "Wade", Construction supervisor, will do a walk through to verify these doors have been corrected.

K 029

Oakland was informed that doors have been propped open and door closers have been disabled by construction workers. They have informed their sub contractors at their weekly sub meeting on 01/26/10 and fix the problems. "Clyde" and "Wade" walked through the space on 01/28/10 and found all closers operating properly with no props on the doors. The Engineering staff have been alerted to this issue and have been asked to report if they find doors propped open the "Clyde".

K 039

The table and chairs in the Paragon were moved on 1/28/10 out of path of exit. "Don", Food Service Manager, will monitor to ensure it stays clear. If the exit does not stay clear of the table and chairs they will be permanently removed from area by the Engineering Department. "Betty", Director of Surgery Services and Engineering have worked to get different shelving installed next to the desk in the corridor leading form the O.R. suits to the exit to prevent this corridor being blocked. The shelving is scheduled to be here and installed by 02/12/10. The shred box has been moved into decontam room. The surgery staff have been notified and will monitor to keep the exits clear. In order to provide a 44 inch exit in the break down corridor "Betty" has talked with the Striker representative and he will have his box out by 02/19/10. "Betty" will get some asset disposal forms filled out by 02/12/10 so that we can move other pieces of unused equipment out of the way and keep things on the carts. "Jearold" has been assigned to monitor this hall so it does not move into the 44 inch range. Oakland removed the door in stairwell B on 01/27/10. As Engineering and Housekeeping clean and use the stairs they will monitor to make sure nothing else wanders into this space.

K 046

"Greg", Biomedical Electronics Technician, will have a form created by 2/12/10 to document to show that we are checking the battery operated light monthly for 30 seconds and annually for 1.5 hours. "Stacy", Engineering Secretary, has created a PM to make sure that this is checked monthly. "Clyde" will review on a monthly basis the PM schedule to ensure that this is being completed as scheduled.

K 050

"Stacy" has added quarterly fire drills to "Jack's", Biomedical Technician, PM work list. As this assignment will populate on "Jack's" work list on a quarterly basis "Jack" will ensure that the fire drills are conducted on various shifts and record in the fire drill log when it was done and any issues that were identified. The areas for improvement will be shared with "Luann", Safety Officer, who will make assignments to have them corrected. The data from the fire drills will be reviewed in Safety Committee on a quarterly basis. Our next fire drill has been scheduled to be done by 2/28/10.

K 051

Simplex has been contacted and a representative will be here on 02/02/10 to assess what it will take to do an annual check on the system. They will then give us a price and we will issue a purchase order so it can be done. "Stacy" has made a PM to make sure it is done annually. "Jack" has been assigned to make sure that Simplex is contacted and the fire alarm system has been tested annually. "Clyde" will review the PM schedule on a monthly basis to ensure this is being done as scheduled.

K 054

Before the smoke detectors can be tested the new GCC needs to be installed. It was discussed during construction meeting on 01/28/10 with Oakland what needs to be done. Oakland reported that they will have this done by 3/10/10. Once Oakland has completed "Stacy" will schedule a PM to establish a baseline and a schedule to have the smoke detectors maintained, inspected and tested on an annual basis. "Clyde" will review the PM schedule on a monthly basis to ensure this is being done as scheduled.

Madison Memorial Hospital's Report of Plan of Correction to the Bureau of Facility Standards Life Safety Survey

K 056

By 02/09/10, Shilo Sprinkler Company will put new tags on the fire risers. "Stacy" has assigned a PM to "Jack" to show that maintenance of the automatic fire sprinkler system has been done. "Clyde" will review the PM schedule on a monthly basis to ensure this is being done as scheduled. "Clyde" did a visual check on 01/29/10 which reviled that all the sprinkler heads have been changed by Oakland Construction.

K 062

Shilo Sprinkler Company has been contacted and will be here on 02/09/10 to do the annual inspection of the fire risers and tamper switches. "Stacy" will create a PM and assign it to "Jack" so we do not forget to do it next year. "Clyde" will review the PM schedule on a monthly basis to ensure this is being done as scheduled.

K 066

Since the ground is too frozen to install posts at this time, temporary no smoking signs will be posted by 02/15/10 at the access and egress points of the helicopter pad and permanent signs will be completed by 04/01/10 when the ground is thawed. "Clyde" will verify the temporary signs are placed by 02/15/10, along with verifying that the permanent signs have been installed by 04/01/10.

K 106

The parts to install battery operated lights in the generator room were ordered 02/01/10 and they will be installed by 2/11/10 by "Greg". "Stacy" has added testing these lights/ batteries to the OR battery light PM for "Greg" to do annually. "Clyde" will review the PM schedule on a monthly basis to ensure this is being done as scheduled.

K 144

In the construction meeting 01/28/10 it was discussed with Oakland that we need a hard copy of the generator data. Oakland has agreed to get this to us by 2/26/10. "Stacy" has created a PM to have a monthly report run to verify testing of the auxiliary generator. . "Clyde" will review the PM schedule on a monthly basis to ensure this is being done as scheduled.

K 147

The electrical cord used on the loading deck was removed on 1/27/10. The items blocking the fire panel on level 3 were removed on 01/27/10. "Luann" has added to the safety check list a prompt to look for improper use of electrical cords and for items blocking the fire panels. An e-mail was also sent from "Clyde" informing staff concerning the use of electrical cords and keeping access to fire panels clear.

K 211

A work order was issued to "Corey", Maintenance Technician, to have the hand sanitizers in the ER and security desk moved by 2/15/10. "Clyde" will do a walkthrough of the building by 2/15/10 to verify that all hand sanitizers have been properly placed.

BB 504

"Luann", Safety Officer, will conduct training with administration, engineering, and house supervisors on the fire policy. Minutes will be kept of this training in the employee's education files. A statement will be added to the fire policy by "Luann" that outlines that the Safety Officer will be responsible for reporting fires to the State. "Jack", Bio-medical Tech, will record and note monthly in the fire log any fires, which will be stored on the V: drive in Engineering. Each of these will be completed by 2/19/10.